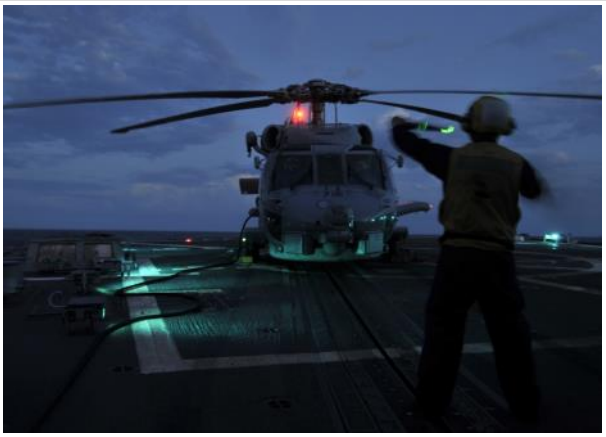
Naval Safety Command

SANITIZED SAFETY INVESTIGATION REPORT

SSIR 22-04

DARKEN SHIP FATAL LADDER FALL



NON-PRIVILEGED MISHAP DESCRIPTION:

A Sailor suffered a fatal fall from an exterior ladder of the ship. Class A Mishap.

NARRATIVE:

A ship had just completed a night-time flight quarters (FQ) and was independently steaming in waters in an overseas theater of operations. Upon securing from FQ, a Sailor and his supervisor departed from the flight deck, walking topside along an 0-2 level catwalk past the starboard boat deck to get to the 0-1 level. They intended to check Dog Zebra fittings and ensure proper rigging of a replenishment at sea (RAS) station for a scheduled RAS the following day. While they were together on the 02 level, the supervisor did not see the Sailor fall from the 02 level to the 01 level, but he heard the sound of a steel -toed boot hitting a knife-edge and noted the white FQ jersey the Sailor was wearing disappeared down the ladder well. The supervisor investigated and, finding the Sailor lying injured on the 01 level, he rushed to the closest available phone (integrated voice communication system – IVCS) in the wardroom to have the bridge call away a medical emergency. No IVCS was readily available at the mid-ship quarterdeck because the quarterdeck had been previously shifted to the fantail during a recent port visit.

The Sailor suffered a severe head injury with a skull fracture and was transported to medical, where the senior medical officer and his team provided urgent care. He was medically evacuated (MEDEVAC) by helicopter to a local foreign hospital, but he was pronounced dead upon arrival.

MISHAP COSTS:

Personnel information, injuries, and costs: 1 Fatality

REPORT CAUSAL FACTORS:

1. The Sailor and his supervisor departed the flight deck via a topside route to the starboard boat deck without first notifying the officer of the deck (bridge controlling station), as required per the Commanding Officer's Standing Orders. Contacting the bridge would have given the command an opportunity to provide forceful backup and reinforce good risk management, possibly preventing the mishap.

2. The lack of immediate access to Level 1 trauma care (to include head imaging and a neurosurgeon) could have contributed to the severity of the mishap. The ship's medical personnel did everything within their capabilities to save the Sailor's life, but they did not have access to the higher-level medical expertise or equipment to address such injuries. Although the ship made every effort to expedite the MEDEVAC, several actions could have been accomplished ahead of the mishap to streamline the process.

THIS IS A SANITIZED, NON-PRIVILEGED, LIMITED-USE SAFETY INVESTIGATION REPORT INTENDED TO ASSIST IN TRAINING AND MISHAP PREVENTION.

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REPORT RECOMMENDATIONS FOR UNIT:

A. For the mishap ship Commanding Officer (CO):

1. Immediately conduct a CO-led safety stand-down, and plan to emphasize safety while traversing the ship as an integral part of follow-on stand-downs.

2. Create/update the command's indoctrination (INDOC) program emphasizing the hazards involved with traversing a warship - especially during periods of darken ship.

3. Update and persistently enforce the command's darken ship policy. Consider a "two-man integrity" concept for personnel topside after dark and ensure all personnel request permission to operate topside after dark.

4. Verify topside safety to include the following: Ensure proper installment and use of safety lanyards/ chains topside; if permitted, illuminate dangerous trip hazards with tape/paint; ensure all ladder landings are clear of excessive gear (toolboxes, foreign objects); and install protective (rubber) guards/flashing on all sharp edges in the vicinity of hand bars above ladder wells.

5. Conduct ship-wide MEDEVAC Integrated Team Training (ITT) Drill/Chalk Talk with all key shipboard stations and aviation department representatives.

6. Reassess communication equipment with consideration for the following: A) Ensure forward battle dressing station and main medical are equipped with IVCS for the purposes of accessing designated IVCS nets. B) Ensure main medical has access to an outside phone line to call off the ship. C) Move the quarterdeck IVCS to the mid-ship quarterdeck when underway.

7. Designate a MEDEVAC coordinator (not a Hospital Corpsman) that tracks available medical facilities as the ship changes location.

Key Takeaways/Lessons Learned

1. **CO's Standing Orders are not optional.** The CO had a standing order in place requiring all hands to gain permission from a controlling station before traversing topside after dark, which was not followed in this case. Contacting the controlling station isn't just a check in the block. The notification affords the command an opportunity to provide forceful backup and to reinforce risk management. Controlling stations must use that opportunity to quickly verify that environmental and operational conditions don't pose a hazard unknown to the requesting Sailor and the Sailor is taking adequate measures to reduce the risk … the correct PPE (float coat, flashlight, etc.), using the buddy system, checking back in with the controlling station when the evolution is complete, etc.

2. **Train for the most complicated scenarios.** Although it may not have been enough to save this victim's life, conducting an integrated training team drill that exercised internal and external communications may have increased his chances for survival.

3. **"...Planning is everything" – Dwight D. Eisenhower.** Include MEDEVAC options in pre-deployment planning. Coordinate with your operational commander's staff regarding level 1 trauma facilities available within the planned operating area/s. Designate a MEDEVAC coordinator who is aware of onboard medical expertise and shortfalls. Charge the coordinator with consistently tracking the ship's location and all available local medical facilities and their capabilities. Having this information readily available will save precious, lifesaving minutes when a mishap actually occurs.